



Facility Name & ID Number Alden Alma Nelson Manor# 0044891 Report Period Beginning: 1/1/04 Ending: 12/31/04

## III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,  
(must agree with license). Date of change in licensed beds \_\_\_\_\_

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	<u>268</u>	Skilled (SNF)	<u>268</u>	<u>98,088</u>	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	<u>268</u>	TOTALS	<u>268</u>	<u>98,088</u>	7

## B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	<u>16,283</u>	<u>5,442</u>	<u>21,305</u>	<u>43,030</u>	8
9	SNF/PED					9
10	ICF	<u>33,392</u>	<u>2,426</u>	<u>129</u>	<u>35,947</u>	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	<u>49,675</u>	<u>7,868</u>	<u>21,434</u>	<u>78,977</u>	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed  
bed days on line 7, column 4.) 80.52%

D. How many bed-hold days during this year were paid by Public Aid?

0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.  
(E.g., day care, "meals on wheels", outpatient therapy)none

F. Does the facility maintain a daily midnight census?

YesG. Do pages 3 & 4 include expenses for services or  
investments not directly related to patient care?YES ☐ NO ☒

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?

YES ☐ NO ☒

I. On what date did you start providing long term care at this location?

Date started 8/1/00

J. Was the facility purchased or leased after January 1, 1978?

YES ☒ Date 8/1/00 NO ☐

K. Was the facility certified for Medicare during the reporting year?

YES ☒ NO ☐ If YES, enter numberof beds certified 128 and days of care provided 21,078Medicare Intermediary Administar Federal

## IV. ACCOUNTING BASIS

ACCRUAL ☒ MODIFIED CASH\* ☐ CASH\* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: 12/31/04 Fiscal Year: 12/31/04

\* All facilities other than governmental must report on the accrual basis.

## STATE OF ILLINOIS

Page 3

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY	
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10
	<b>A. General Services</b>										
1	Dietary	350,572	34,687	9,600	394,859	350	395,209		395,209		1
2	Food Purchase		434,509		434,509	(35,338)	399,171	(1,276)	397,895		2
3	Housekeeping	288,467	52,274		340,741	936	341,677		341,677		3
4	Laundry	69,651	39,987		109,638	240	109,878		109,878		4
5	Heat and Other Utilities			242,859	242,859		242,859	(715)	242,144		5
6	Maintenance	65,787		126,987	192,774		192,774	12,436	205,210		6
7	Other (specify):* Related Party Salary							58,407	58,407		7
8	<b>TOTAL General Services</b>	774,477	561,457	379,446	1,715,380	(33,812)	1,681,568	68,852	1,750,420		8
	<b>B. Health Care and Programs</b>										
9	Medical Director			39,000	39,000		39,000		39,000		9
10	Nursing and Medical Records	4,108,379	330,434	54,140	4,492,953	7,871	4,500,824	(199,146)	4,301,678		10
10a	Therapy	204,127			204,127		204,127		204,127		10a
11	Activities	105,195	2,151	4,540	111,886	162	112,048		112,048		11
12	Social Services	84,128			84,128		84,128		84,128		12
13	Nurse Aide Training										13
14	Program Transportation										14
15	Other (specify):* Related Party Salary							43,676	43,676		15
16	<b>TOTAL Health Care and Programs</b>	4,501,829	332,585	97,680	4,932,094	8,033	4,940,127	(155,470)	4,784,657		16
	<b>C. General Administration</b>										
17	Administrative	158,184			158,184		158,184		158,184		17
18	Directors Fees										18
19	Professional Services			1,185,828	1,185,828		1,185,828	(992,512)	193,316		19
20	Dues, Fees, Subscriptions & Promotions			62,200	62,200		62,200	(47,217)	14,983		20
21	Clerical & General Office Expenses	295,728	24,593	133,184	453,505	74	453,579	89,224	542,803		21
22	Employee Benefits & Payroll Taxes			992,240	992,240	25,705	1,017,945	(6,713)	1,011,232		22
23	Inservice Training & Education										23
24	Travel and Seminar			26,663	26,663		26,663	18,860	45,523		24
25	Other Admin. Staff Transportation										25
26	Insurance-Prop.Liab.Malpractice			233,968	233,968		233,968	10,509	244,477		26
27	Other (specify):* Related Party Salary			171,719	171,719		171,719	387,173	558,892		27
28	<b>TOTAL General Administration</b>	453,912	24,593	2,805,802	3,284,307	25,779	3,310,086	(540,676)	2,769,410		28
29	<b>TOTAL Operating Expense (sum of lines 8, 16 &amp; 28)</b>	5,730,218	918,635	3,282,928	9,931,781		9,931,781	(627,294)	9,304,487		29

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

## STATE OF ILLINOIS

Page 4

Facility Name &amp; ID Number Alden Alma Nelson Manor

#0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

## V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification 5	Reclassified Total 6	Adjust- ments 7	Adjusted Total 8	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4					9	10	
	<b>D. Ownership</b>											
30	Depreciation			41,374	41,374		41,374	342,830	384,204			30
31	Amortization of Pre-Op. & Org.							6,420	6,420			31
32	Interest			(5,454)	(5,454)		(5,454)	388,545	383,091			32
33	Real Estate Taxes							195,395	195,395			33
34	Rent-Facility & Grounds			804,700	804,700		804,700	(803,524)	1,176			34
35	Rent-Equipment & Vehicles			17,924	17,924		17,924	31,656	49,580			35
36	Other (specify):* Mortgage Insurance							40,924	40,924			36
37	<b>TOTAL Ownership</b>			858,544	858,544		858,544	202,246	1,060,790			37
	<b>Ancillary Expense</b>											
	<b>E. Special Cost Centers</b>											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		1,276,445	1,795,251	3,071,696		3,071,696	(465,062)	2,606,634			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			147,788	147,788		147,788		147,788			42
43	Other (specify):*											43
44	<b>TOTAL Special Cost Centers</b>		1,276,445	1,943,039	3,219,484		3,219,484	(465,062)	2,754,422			44
45	<b>GRAND TOTAL COST</b> (sum of lines 29, 37 & 44)	5,730,218	2,195,080	6,084,511	14,009,809		14,009,809	(890,110)	13,119,699			45

\*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Alden Nursing Center - Alma Nelson

Page 4A

Reporting Period Beginning

1/01/04

Reporting Period Ending

12/31/04

Reclassifications - Pgs 3 and 4

From Line	To Line	Amount	Description
2		(35,338)	Employee Meal
	22	35,338	Employee Meal
22		(9,633)	Uniforms
	1	350	Uniforms
	3	936	Uniforms
	4	240	Uniforms
	10	7,871	Uniforms
	11	162	Uniforms
	21	74	Uniforms
			Uniforms
		<hr/>	
		0	Net should be 0

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer- ence	3 OHF USE ONLY	
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(1,043)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(4,356)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees	(12,295)	21		17
18	Fines and Penalties	(71,587)	32		18
19	Entertainment	(520)	20		19
20	Contributions	(3,556)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(15,081)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(171,720)	27		24
25	Fund Raising, Advertising and Promotional	(40,125)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (320,283)		\$	30

OHF USE ONLY						
48		49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)	(386,596)	Various	34
35	Other- Attach Schedule	(183,231)	Pg 5A	35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ (569,827)		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B) )	\$ (890,110)		37

\*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	\$		38
39			X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule		X			45
46	Other-Attach Schedule		X			46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Alden Alma Nelson Manor

ID# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

Sch. V Line

NON-ALLOWABLE EXPENSES		Amount	Reference	
1	Late fees on utilities	\$ (5,043)	5	1
2	Intercompany interest	(2,746)	32	2
3	Intercompany interest on note	(26,428)	32	3
4	Marketing manager	(38,768)	21	4
5	Back out empl benefits (% of Mktg Mnr salary)	(6,713)	22	5
6	Back out pac 31.78% of IHCA dues	(3,775)	20	6
7	Alma LLC - Int to Related Party - Rockford Inv.	(18,800)	32	7
8	Back out prior year vendor settlements	(8,000)	21	8
9	Back out prior year vendor settlements	(8,900)	21	9
10	Back out prior year vendor settlements	(6,000)	21	10
11	Back out prior year vendor settlements	(316)	21	11
12	FAS Interest	(32,419)	32	12
13	AMS Intercompany Interest (LLC)	(24,693)	32	13
14	Adj depreciation to correct amt on detail	2,866	30	14
15	Adj Deferred Maint depr exp for 2004 painting	146	6	15
16	Back out legal collections - Aaby	(7,119)	19	16
17	Back out RC of 2002 cost	1,000	19	17
18	Back out legal collections - Fisch	(267)	19	18
19	Back out 2003 voids	2,494	19	19
20	Back out 2002 accrued legal write off	250	19	20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	(183,231)		49

## STATE OF ILLINOIS

Summary A

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	<b>A. General Services</b>													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(4,356)	0	0	3,080	0	0	0	0	0	0	0	(1,276)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	(5,043)	0	4,328	0	0	0	0	0	0	0	0	(715)	5
6	Maintenance	146	0	12,928	0	0	0	(27)	(611)	0	0	0	12,436	6
7	Other (specify):*	0	0	58,407	0	0	0	0	0	0	0	0	58,407	7
8	<b>TOTAL General Services</b>	<b>(9,253)</b>	<b>0</b>	<b>75,663</b>	<b>3,080</b>	<b>0</b>	<b>0</b>	<b>(27)</b>	<b>(611)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>68,852</b>	<b>8</b>
	<b>B. Health Care and Programs</b>													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	(191,363)	(7,783)	0	0	0	0	0	0	(199,146)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	43,676	0	0	0	0	0	0	0	0	43,676	15
16	<b>TOTAL Health Care and Programs</b>	<b>0</b>	<b>0</b>	<b>43,676</b>	<b>(191,363)</b>	<b>(7,783)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(155,470)</b>	<b>16</b>
	<b>C. General Administration</b>													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(18,723)	32,896	(1,006,685)	0	0	0	0	0	0	0	0	(992,512)	19
20	Fees, Subscriptions & Promotions	(47,976)	0	759	0	0	0	0	0	0	0	0	(47,217)	20
21	Clerical & General Office Expenses	(74,279)	0	49,006	92,161	22,336	0	0	0	0	0	0	89,224	21
22	Employee Benefits & Payroll Taxes	(6,713)	0	0	0	0	0	0	0	0	0	0	(6,713)	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	18,860	0	0	0	0	0	0	0	0	18,860	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	10,092	417	0	0	0	0	0	0	0	0	10,509	26
27	Other (specify):*	(171,720)	0	502,657	21,618	34,618	0	0	0	0	0	0	387,173	27
28	<b>TOTAL General Administration</b>	<b>(319,411)</b>	<b>42,988</b>	<b>(434,986)</b>	<b>113,779</b>	<b>56,954</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(540,676)</b>	<b>28</b>
29	<b>TOTAL Operating Expense (sum of lines 8,16 &amp; 28)</b>	<b>(328,664)</b>	<b>42,988</b>	<b>(315,647)</b>	<b>(74,504)</b>	<b>49,171</b>	<b>0</b>	<b>(27)</b>	<b>(611)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(627,294)</b>	<b>29</b>



## STATE OF ILLINOIS

Summary B

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

## SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)
	<b>D. Ownership</b>												
30	Depreciation	2,866	329,422	9,144	0	1,398	0	0	0	0	0	0	342,830 30
31	Amortization of Pre-Op. & Org.	0	3,919	2,501	0	0	0	0	0	0	0	0	6,420 31
32	Interest	(177,716)	487,338	70,936	0	1,602	6,385	0	0	0	0	0	388,545 32
33	Real Estate Taxes	0	183,504	10,369	0	1,522	0	0	0	0	0	0	195,395 33
34	Rent-Facility & Grounds	0	(804,738)	1,214	0	0	0	0	0	0	0	0	(803,524) 34
35	Rent-Equipment & Vehicles	0	0	31,656	0	0	0	0	0	0	0	0	31,656 35
36	Other (specify):*	0	40,924	0	0	0	0	0	0	0	0	0	40,924 36
37	<b>TOTAL Ownership</b>	<b>(174,850)</b>	<b>240,369</b>	<b>125,820</b>	<b>0</b>	<b>4,522</b>	<b>6,385</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>202,246 37</b>
	<b>Ancillary Expense</b>												
	<b>E. Special Cost Centers</b>												
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0 38
39	Ancillary Service Centers	0	0	0	(85,026)	(116,017)	(264,019)	0	0	0	0	0	(465,062) 39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0 40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0 41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0 42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0 43
44	<b>TOTAL Special Cost Centers</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(85,026)</b>	<b>(116,017)</b>	<b>(264,019)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(465,062) 44</b>
	<b>GRAND TOTAL COST</b>												
45	<b>(sum of lines 29, 37 &amp; 44)</b>	<b>(503,514)</b>	<b>283,357</b>	<b>(189,827)</b>	<b>(159,530)</b>	<b>(62,324)</b>	<b>(257,634)</b>	<b>(27)</b>	<b>(611)</b>	<b>0</b>	<b>0</b>	<b>0</b>	<b>(890,110) 45</b>

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

## VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Alden Rockford Investments, LLC	100					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34 Rent Income	\$ 804,738	Alma Nelson Manor, LLC	100.00%	\$	\$ (804,738)	1
2	V	32 Investment Income - RR	1,067	Alma Nelson Manor, LLC			(1,067)	2
3	V	32 Investment - Misc	19,829	Alma Nelson Manor, LLC			(19,829)	3
4	V	19 Accounting Fee		Alma Nelson Manor, LLC		10,000	10,000	4
5	V	19 Misc. Admin Expense		Alma Nelson Manor, LLC		22,896	22,896	5
6	V	33 Real Estate Tax		Alma Nelson Manor, LLC		183,504	183,504	6
7	V	26 Property & Liability Insur		Alma Nelson Manor, LLC		10,092	10,092	7
8	V	32 Interest On Mortg. Note		Alma Nelson Manor, LLC		432,322	432,322	8
9	V	36 Mortgage Insurance Premium		Alma Nelson Manor, LLC		40,924	40,924	9
10	V	32 AMS Interest		Alma Nelson Manor, LLC		24,693	24,693	10
11	V	32 Note & Rockford, LLC Interest		Alma Nelson Manor, LLC		51,219	51,219	11
12	V	30 Depreciation		Alma Nelson Manor, LLC		329,422	329,422	12
13	V	31 Amortization		Alma Nelson Manor, LLC		3,919	3,919	13
14	Total		\$ 825,634			\$ 1,108,991	\$ * 283,357	14

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	19 Professional fees	\$ 1,022,003	Alden Management Services	0.00%	\$ 15,318	\$ (1,006,685)	15
16	V	21 Clerical and G & A		Alden Management Services		49,006	49,006	16
17	V	5 Utilities		Alden Management Services		4,328	4,328	17
18	V	6 Maintenance		Alden Management Services		12,928	12,928	18
19	V	24 Travel & seminar		Alden Management Services		18,860	18,860	19
20	V	26 Insurance		Alden Management Services		417	417	20
21	V	20 Dues/subscriptions/fees etc		Alden Management Services		759	759	21
22	V	30 Depreciation		Alden Management Services		9,144	9,144	22
23	V	31 Amortization		Alden Management Services		2,501	2,501	23
24	V	33 Real estate taxes		Alden Management Services		10,369	10,369	24
25	V	34 Rent-facilities		Alden Management Services		1,214	1,214	25
26	V	35 Rent-equipment/vehicles		Alden Management Services		31,656	31,656	26
27	V	32 Interest		Alden Management Services		70,936	70,936	27
28	V	7 Salaries-general serv		Alden Management Services		58,407	58,407	28
29	V	15 Salaries-health care		Alden Management Services		43,676	43,676	29
30	V	27 Salaries-general admin		Alden Management Services		502,657	502,657	30
31	V			Alden Management Services				31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,022,003			\$ 832,176	\$ * (189,827)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	2 Tube Feeding	\$ 35,108	Pyramid Health Care	0.00%	\$ 38,188	\$ 3,080	15
16	V	10 Nursing Supply	207,745	Pyramid Health Care		16,382	(191,363)	16
17	V	39 Per Diems/Other Supplies	193,240	Pyramid Health Care		108,214	(85,026)	17
18	V	21 General & Admin		Pyramid Health Care		92,161	92,161	18
19	V	27 General & Admin Salaries		Pyramid Health Care		21,618	21,618	19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 436,093			\$ 276,563	\$ * (159,530)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Drugs	\$ 512,875	Forum Extended Care II	0.00%	\$ 442,375	\$ (70,500)	15
16	V	10 House Stock	8,914	Forum Extended Care II		7,688	(1,226)	16
17	V	39 IV	331,129	Forum Extended Care II		285,612	(45,517)	17
18	V	21 G & A		Forum Extended Care II		22,336	22,336	18
19	V	32 Interest		Forum Extended Care II		1,602	1,602	19
20	V	33 Real Estate Taxes		Forum Extended Care II		1,522	1,522	20
21	V	30 Depreciation		Forum Extended Care II		1,398	1,398	21
22	V	27 General & Admin Salaries		Forum Extended Care II		34,618	34,618	22
23	V	10 Pharmacy Consulting	6,557	Forum Extended Care II			(6,557)	23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 859,475			\$ 797,151	\$ * (62,324)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	39 Therapy	\$ 1,731,532	Community Physical Therapy	0.00%	\$ 1,467,513	\$ (264,019)	15
16	V	32 Interest		Community Physical Therapy		6,385	6,385	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 1,731,532			\$ 1,473,898	\$ * (257,634)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)	
15	V	6 Maintenance Expense	\$ 18,796	Alden Bennett Construction	0.00%	\$ 18,769	\$ (27)	15
16	V							16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 18,796			\$ 18,769	\$ * (27)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☒ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V	2 Line	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
		Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization		
15	V	6 Carpet Cleaning	\$ 358	Alden Realty - Carpet Care	0.00%	\$ 320	\$ (38)	15
16	V	6 Floor Cleaning	5,880	Alden Realty - Floor Care		5,307	(573)	16
17	V							17
18	V							18
19	V							19
20	V							20
21	V							21
22	V							22
23	V							23
24	V							24
25	V							25
26	V							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							35
36	V							36
37	V							37
38	V							38
39	Total		\$ 6,238			\$ 5,627	\$ * (611)	39

\* Total must agree with the amount recorded on line 34 of Schedule VI.



## STATE OF ILLINOIS

Page 6K

Facility Name &amp; ID Number ALDEN NURSING CENTER - ALMA NELSON

# 42010

Report Period Beginning 01/01/04

Ending: 12/31/04

RELATED NURSING HOMES	
Name	City
Note: ANC = Alden Nursing Center	
ANC Lakeland	Chicago
ANC Long Grove	Long Grove
ANC Heather	Harvey
ANC Lincoln Park	Chicago
ANC Northmoor	Chicago
ANC Town Manor	Chicago
ANC Terrace of McHenry	McHenry
ANC Morrow	Chicago
ANC Wentworth	Chicago
ANC Naperville	Naperville
ANC Valley Ridge	Bloomington
ANC Village for Children & Young Adults	Bloomington
ANC Orland Park	Orland Park
ANC Princeton	Chicago
Alden of Old Town East	Bloomington
Alden of Old Town West	Bloomington
Alden Trails	Bloomington
Alden Northshore	Skokie
ANC Des Plaines	Des Plaines
ANC Des Plaines II	Des Plaines
ANC Waterford	Aurora
ANC Park Stratmoor	Rockford
ANC Meadow Park	Rockford
ANC Poplar Creek	Hoffman Estates
ANC Governor's Park of Barrington	Barrington
ANC Gardens of Rockford	Rockford

OTHER RELATED BUSINESS ENTITIES		
Name	City	Type of Business
The Forum Prof. Center	Chicago	Office rental
Pyramid Health Care	Chicago	Nursing supplies
Forum Extended Care II	Chicago	Pharmacy
Alden Management	Chicago	Management
Alden Estates of Evanston	Evanston	Assisted living
Community Physical Therapy	Wood Dale	Therapy provider
Courts of Waterford	Aurora	Alzheimers unit
Gardens of Waterford	Aurora	Assisted living
Governors Park		

## STATE OF ILLINOIS

Page 7

Facility Name & ID Number Alden Alma Nelson Manor # 0044891 Report Period Beginning: 1/1/04 Ending: 12/31/04

## VII. RELATED PARTIES (continued)

## C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

**NOTE: ALL owners ( even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.**

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Floyd Schlossberg a.	President	CEO	90.51	211,995	2.768	6.92	salary	\$ 15,769	27-7	1
2											2
3											3
4	Lauren Magnusson b.	Nurse coordinator	Nursing admin		68,457	2.768	6.92	salary	5,092	15-7	4
5	Terry Magnusson c.	Maint. Supervisor	construt/maint		46,538	2.768	6.92	salary	3,462	7-7	5
6											6
7											7
8											8
9	a. Floyd Schlossberg is the President and sole stockholder of Alden Management Services, Inc. and Alden Realty, of which he owns 100%.										9
10	b. Lauren is the daughter of Floyd Schlossberg. Lauren is a nurse coordinator										10
11	c. Terry is the son-in-law of Floyd Schlossberg. Terry is in maintenance and construction.										11
12											12
13								TOTAL	\$ 24,323		13

\* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

\*\* This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees).  
FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME.  
ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Alden Alma Nelson Manor# 0044891

Report Period Beginning:

1/1/04Ending: 12/31/04

## VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Alden Management Services, Inc.Street Address 4200 W. Peterson Ave.City / State / Zip Code Chicago, IL 60646Phone Number ( 773-286-3883Fax Number ( 773-286-3473

B. Show the allocation of costs below. If necessary, please attach worksheets.

1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	See Page 8A (also on Page 6A)				\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE**

**A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)**

1		2		3		4		5		6		7		8		9		10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense								
		YES	NO				Original	Balance											
	A. Directly Facility Related																		
	Long-Term																		
1	Cambridge		X	Mortgage	\$65,430.00	09/04	\$ 12,036,800	\$ 11,893,293	09/39	5.6000	\$ 432,322	1							
2	National City Bank		X	Line of Credit-paid off	Interest Only	08/00	1,411,117				46,577	2							
3	Discount on Debes Note										(152,792)	3							
4												4							
5												5							
	Working Capital																		
6	Related Party - AMS	X		Working Capital							70,936	6							
7	Related Party - FECII	X		Working Capital							1,602	7							
8	Realted Party - CPT	X		Working Capital							6,385	8							
9	TOTAL Facility Related					\$65,430.00		\$ 13,447,917	\$ 11,893,293			\$ 405,030	9						
	B. Non-Facility Related*																		
10	Interest Inc on corp										(1,043)	10							
11	Interest Inc on LLC										(20,896)	11							
12												12							
13												13							
14	TOTAL Non-Facility Related							\$	\$			\$ (21,939)	14						
15	TOTALS (line 9+line14)							\$ 13,447,917	\$ 11,893,293			\$ 383,091	15						

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. \$ 40,924 Line # 36

\* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.  
(See instructions.)

\*\* If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.  
(See instructions.)

## B. Real Estate Taxes

**NOTES:**

1. Please indicate a negative number by use of brackets ( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.  
**This denial must be no more than four years old at the time the cost report is filed.**

**IMPORTANT NOTICE**

**TO:** Long Term Care Facilities with Real Estate Tax Rates    **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

**Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed.** If you have any questions, please call the Office of Health Finance at (217) 782-1630.

**2003 LONG TERM CARE REAL ESTATE TAX STATEMENT**

FACILITY NAME    Alden Alma Nelson Manor                      COUNTY    Winnebago

FACILITY IDPH LICENSE NUMBER    0044891

CONTACT PERSON REGARDING THIS REPORT    Steven M. Kroll

TELEPHONE    773-286-3883                      FAX #:    773-286-3743

**A.    Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

(A)	(B)	(C)	(D) <u>Tax</u> <u>Applicable to</u> <u>Nursing Home</u>
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	
1. <u>12-27-152-003</u>	<u>Nursing home facility</u>	\$ <u>6,196.74</u>	\$ <u>6,196.74</u>
2. <u>12-27-152-002</u>	<u>Nursing home facility</u>	\$ <u>87,225.08</u>	\$ <u>87,225.08</u>
3. <u>12-27-152-001</u>	<u>Nursing home facility</u>	\$ <u>86,755.86</u>	\$ <u>86,755.86</u>
4. _____	<u>Related Party - Alden Management</u>	\$ <u>149,765.00</u>	\$ <u>10,369.00</u>
5. _____	<u>Related Party - Forum</u>	\$ <u>13,827.00</u>	\$ <u>1,522.00</u>
6. _____	_____	\$ _____	\$ _____
7. _____	_____	\$ _____	\$ _____
8. _____	_____	\$ _____	\$ _____
9. _____	_____	\$ _____	\$ _____
10. _____	_____	\$ _____	\$ _____
<b>TOTALS</b>		\$ <u><u>343,769.68</u></u>	\$ <u><u>192,068.68</u></u>

**B.    Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services?           YES      X   NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

**C.    Tax Bills**

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

A. Square Feet:
60,952

B. General Construction Type:

Exterior
Brick

Frame
Steel

Number of Stories
1

C. Does the Operating Entity?

☐ (a) Own the Facility
☒ (b) Rent from a Related Organization.
☐ (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity?

☐ (a) Own the Equipment
☒ (b) Rent equipment from a Related Organization.
☐ (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized?

☐ YES
☒ NO

If so, please complete the following:

1. Total Amount Incurred:

2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization:

4. Dates Incurred:

Nature of Costs:

(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home			\$ 700,000	1
2					2
3	TOTALS			\$ 700,000	3

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	268				\$ 7,000,000	\$ 222,222	31.5	\$ 222,222	\$	\$ 981,481	4
5											5
6											6
7											7
8	Related party-Forum			1978	16,213		22			16,213	8
	<b>Improvement Type**</b>										
9	GT Mechanical - replace 75 ton compressor			2000	23,550	2,355	10	2,355		10,205	9
10	Building Improvements			2000	5,142	257	20	257		1,093	10
11	Alden Design - HVAC			2000	3,089	154	20	154		656	11
12	Alden Bennett Const.			2001	16,737	1,674	10	1,674		6,556	12
13	Pro com systems			2001	4,055	406	10	406		1,588	13
14	Alden Bennett Const.			2001	2,098	210	10	210		787	14
15	New Horz. Comm			2001	1,701	170	10	170		624	15
16	Alden Bennett Const.			2001	1,816	192	10	192		666	16
17	Alden Bennett Const.			2001	2,263	226	10	226		611	17
18	Alden Bennett Const.			2001	2,828	283	10	283		990	18
19	Seams -rebuild engine			2001	4,938	494	10	494		1,687	19
20	Alden Bennett Const.			2001	1,632	163	10	163		558	20
21	CST Coker - belt/heating element			2001	5,256	526	10	526		1,664	21
22	Alden Bennett Const.			2001	3,198	320	10	320		1,013	22
23	GT Mechanical - heater			2001	2,406	241	10	241		742	23
24	Alden Design - elect. /plumbing			2001	22,472	1,124	20	1,124		4,494	24
25	Alden Design - misc			2001	22,412	1,121	20	1,121		4,482	25
26	Alden Design - misc			2001	94,243	4,712	20	4,712		18,456	26
27	ABC - laundry room repairs			2001	11,608	580	20	580		2,080	27
28	ABC - laundry room repairs			2001	9,602		20			40	28
29	ABC - laundry room repairs			2002	(9,602)		20			(40)	29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

\*Total beds on this schedule must agree with page 2.

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total



## STATE OF ILLINOIS

Page 12A

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning:

1/1/04

Ending:

12/31/04

**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation		
37	GT Mechanical, Inc. - Repair Air Conditioner	2002	\$ 11,519	\$ 1,152	10	\$ 1,152	\$	\$ 2,880		37
38	Pro Com Systems - Repair Nurse Call System	2002	1,862	186	10	186		497		38
39	GT Mechanical, Inc. - Repair Heater	2002	1,996	200	10	200		582		39
40	FE Moran - Repair - Fire Alarm System	2002	1,825	183	10	183		441		40
41	Nelson Carlson - Repair Water Main	2002	2,407	241	10	241		702		41
42	ABC - Carpet	2002	1,231	82	20	82		164		42
43	ABC - Chimney	2002	3,032	152	20	152		303		43
44	Medline - Window Blinds	2003	1,706	244	7	244		467		44
45	Tvco - installation of smoke detectors	2003	6,753	450	15	450		900		45
46	Code Alert - Update system	2003	5,007	334	15	334		501		46
47	ABC - 4 doors	2003	2,449	245	10	245		265		47
48	ABC - Light Fixtures	2003	2,283	457	5	457		913		48
49	GT Mech - Replace Pump	2003	1,532	153	10	153		255		49
50	Simplex - Repair Smoke Detector system	2003	4,238	424	10	424		706		50
51	ABC - Roof Repair	2003	3,953	264	15	264		439		51
52	CSI Coker - Repair Dishwasher	2003	3,291	470	7	470		666		52
53	ABC - Repair C wing main A/C power	2003	2,177	218	10	218		308		53
54	ABC - Repair Boiler	2003	23,646	1,576	15	1,576		1,708		54
55	ABC-Roof repairs	2004	3,102	181	10	181		181		55
56	ABC-Roof repairs	2004	3,486	291	10	291		291		56
57	ABC-Roof repairs	2004	4,565	304	10	304		304		57
58	Equipment Int'l LTD-repair laundry	2004	1,714	157	10	157		157		58
59	CSI Coker - Repair Dishwasher	2004	2,387	199	10	199		199		59
60	CSI Coker - Repair Dishwasher	2004	2,917	219	10	219		219		60
61	GT Mechanical-furnace repair	2004	1,765	118	10	118		118		61
62	GT Mechanical-a/c repair	2004	2,128	142	10	142		142		62
63	ABC-boiler repairs	2004	1,877	94	10	94		94		63
64	GT Mechanical-Expansion tank replacement	2004	5,925	99	10	99		99		64
65	GT Mechanical-heater repair	2004	5,536	46	10	46		46		65
66										66
67										67
68										68
69										69
70	TOTAL (lines 4 thru 69)		\$ 7,363,966	\$ 246,311		\$ 246,311	\$	\$ 1,071,193		70

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)									
B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.									
1	2	3	4	5	6	7	8	9	
	Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		\$ 7,363,966	\$ 246,311		\$ 246,311	\$	\$ 1,071,193	1
2									2
3	Related Party-Forum:								3
4	Leasehold Improvement-Remodeling	1980	12,303		15			12,303	4
5	Leasehold Improvement-Remodeling	1980	19,273		20			19,273	5
6	Leasehold Improvement-Tenant Improvement	1987	996		13			996	6
7	Leasehold Improvement-AMS Remodel	1988	14,339		10			14,339	7
8	Leasehold Improvement-Roof	1994	3,572	223	16	223		2,234	8
9	Leasehold Improvement-Build.Improv.	1996	1,259	79	16	79		704	9
10	Leasehold Improvement-Asphalting	2000	98		3			98	10
11	Leasehold Improvement-DAI	2001	172	17	10	17		54	11
12	Leasehold Improvement-Bathrooms	2002	733	82	7	82		181	12
13	Leasehold Improvement-Suite Renovation	2003	1,638	164	10	164		328	13
14	Leasehold Improvement-Plumbing, Construct, Concrete, Doors, etc	2004	1,820	148	7	148		148	14
15	Leasehold Improvement-Add-on Improvement, fixture base	1980	79		23			79	15
16	Leasehold Improvement-Add-on Improvement, lighting base	2001	137	27	5	27		103	16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26	Related Party-AMS:								26
27	Leasehold Improvement-Remodeling	1993	5,938		7			5,938	27
28	Leasehold Improvement-Remodeling	2002	4,861	608	7	608		1,215	28
29	Leasehold Improvement-Remodeling	2003	5,085	775	7	775		1,394	29
30									30
31									31
32									32
33	Forum Extended Care, LLC-building/building improv	1999	13,393	266	30	266		2,041	33
34	TOTAL (lines 1 thru 33)		\$ 7,449,663	\$ 248,700		\$ 248,700	\$	\$ 1,132,622	34

\*\*Improvement type must be detailed in order for the cost report to be considered complete.

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 711,904	\$ 131,828	\$ 131,828	\$	Various	\$ 550,906	71
72	Current Year Purchases	17,592	2,068	2,068		Various	2,068	72
73	Fully Depreciated Assets	47,882	1,478	1,478		Various	47,882	73
74								74
75	TOTALS	\$ 777,378	\$ 135,374	\$ 135,374	\$		\$ 600,856	75

D. Vehicle Depreciation (See instructions.)\*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Car Engine/Bus/Van	Various/Dodge	98-'04	\$ 8,164	\$ 130	\$ 130	\$	3	\$ 7,981	76
77										77
78										78
79										79
80	TOTALS			\$ 8,164	\$ 130	\$ 130	\$		\$ 7,981	80

E. Summary of Care-Related Assets

	1 Reference	2 Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 8,935,205	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 384,204	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 384,204	83 **
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 1,741,459	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	none	\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

\* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

\*\* This must agree with Schedule V line 30, column 8.

## XII. RENTAL COSTS

### A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: related party- cost is backed out.

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

\*\*

8. List separately any amortization of lease expense included on page 4, line 34.

This amount was calculated by dividing the total amount to be amortized  
by the length of the lease                     .

9. Option to Buy: ☐ YES ☐ NO Terms:                                     \*

### B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental?

☐ YES ☒ NO

16. Rental Amount for movable equipment: \$ 5,532 Description: copy machine \$4,956 postage meter \$576

(Attach a schedule detailing the breakdown of movable equipment)

### C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	<u>non-patient transport</u>		\$ <u>varied</u>	\$ <u>12,392</u>	17
18	<u>Related Party - AMS</u>		<u>2,638.00</u>	<u>31,656</u>	18
19					19
20					20
21	TOTAL		\$ <u>2,638.00</u>	\$ <u>44,048</u>	21

10. Effective dates of current rental agreement:

Beginning                     

Ending                     

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12.                      /2005 \$                     

13.                      /2006 \$                     

14.                      /2007 \$                     

\* If there is an option to buy the building, please provide complete details on attached schedule.

\*\* This amount plus any amortization of lease expense must agree with page 4, line 34.

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p> <p>Skilled Nurses On Site</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------	------------------------------------------------------------------------------------------------------------------------------------------------------------

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility		2	3	4
		Drop-outs	Completed	Contract	Total	
1	Community College Tuition	\$	\$	\$	\$	
2	Books and Supplies					
3	Classroom Wages (a)					
4	Clinical Wages (b)					
5	In-House Trainer Wages (c)					
6	Transportation					
7	Contractual Payments					
8	Nurse Aide Competency Tests					
9	TOTALS	\$	\$	\$	\$	
10	SUM OF line 9, col. 1 and 2 (e)	\$				

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.  
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.  
(c) For in-house training programs only. Do not include fringe benefits.  
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.  
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

**XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)**

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	39-3	hrs	\$		\$ 530,697	\$		\$ 530,697	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			116,537			116,537	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			898,593			898,593	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	See Pg 16 A	# of prescrpts				396,859		396,859	9
	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							
10			hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	See Pg 16 A								12
13	Other (specify):	See Pg 16 A				(264,020)	927,968		663,948	13
14	TOTAL			\$		\$ 1,281,807	\$ 1,324,827		\$ 2,606,634	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Page 16
Col 5: PT,OT, & ST
Col 6: Other
Amount

## XIV. SPECIAL SERVICES (Direct Cost)

## Service

1. OT	39-3	\$530,696.66
2. ST	39-3	116,536.83
3.		
4. PT	39-3	898,593.10
5.		
6.		
7.		
8.		
9. Pharmacy	See pg 16	512,875.10
Plus: Related Party- Forum Drugs		(70,500.00)
Plus: Related Party- Forum I.V.		(45,517.00)
Total to line 9 Pharmacy		396,858.10
10.		
11.		
12. Exceptional Care-Column 3	See pg 16	0.00
12. Exceptional Care-Column 6	See pg 16	0.00
13. Other: Lab, X-Ray Therapy, Mattress, Pyramid Billings	See	992,869.13
Oxygen Cost - IDPA		20,125.00
Related Party- Pyramid		(85,026.00)
Related Party- CPT		(264,020.00)
Total to line 13		663,948.13
14. Total		2,606,632.82

## STATE OF ILLINOIS

Page 17

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending:

12/31/04

## XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/04

(last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	<b>A. Current Assets</b>			
1	Cash on Hand and in Banks	\$ (312,852)	\$ (312,816)	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance (200,000) )	2,855,290	2,855,290	3
4	Supply Inventory (priced at )	848	848	4
5	Short-Term Investments		13,613	5
6	Prepaid Insurance		95,094	6
7	Other Prepaid Expenses	7,655	7,655	7
8	Accounts Receivable (owners or related parties)	21,910	21,910	8
9	Other(specify): Due from 3rd Parties			9
10	<b>TOTAL Current Assets</b> (sum of lines 1 thru 9)	\$ 2,572,851	\$ 2,681,594	10
	<b>B. Long-Term Assets</b>			
11	Long-Term Notes Receivable		1,400,534	11
12	Long-Term Investments			12
13	Land		700,000	13
14	Buildings, at Historical Cost		7,000,000	14
15	Leasehold Improvements, at Historical Cost	356,920	356,920	15
16	Equipment, at Historical Cost	162,904	698,904	16
17	Accumulated Depreciation (book methods)	(139,587)	(1,594,535)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs		1,900,451	19
20	Accumulated Amortization - Organization & Pre-Operating Costs		(56,654)	20
21	Restricted Funds		730,051	21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	<b>TOTAL Long-Term Assets</b> (sum of lines 11 thru 23)	\$ 380,237	\$ 11,135,671	24
25	<b>TOTAL ASSETS</b> (sum of lines 10 and 24)	\$ 2,953,088	\$ 13,817,265	25

		1 Operating	2 After Consolidation*	
	<b>C. Current Liabilities</b>			
26	Accounts Payable	\$ 1,958,976	\$ 2,074,578	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	269,815	269,815	28
29	Short-Term Notes Payable	13,613	13,613	29
30	Accrued Salaries Payable	461,619	461,619	30
31	Accrued Taxes Payable (excluding real estate taxes)	37,801	37,801	31
32	Accrued Real Estate Taxes(Sch.IX-B)		185,600	32
33	Accrued Interest Payable	6,599	62,641	33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	<b>Other Current Liabilities(specify):</b>			
36	Accr Ins,Exps,IDPA,Sales Tax, etc.	159,297	164,472	36
37	Due to Related Parties		121,681	37
38	<b>TOTAL Current Liabilities</b> (sum of lines 26 thru 37)	\$ 2,907,720	\$ 3,391,820	38
	<b>D. Long-Term Liabilities</b>			
39	Long-Term Notes Payable			39
40	Mortgage Payable		11,893,293	40
41	Bonds Payable			41
42	Deferred Compensation			42
	<b>Other Long-Term Liabilities(specify):</b>			
43				43
44				44
45	<b>TOTAL Long-Term Liabilities</b> (sum of lines 39 thru 44)	\$	\$ 11,893,293	45
46	<b>TOTAL LIABILITIES</b> (sum of lines 38 and 45)	\$ 2,907,720	\$ 15,285,113	46
47	<b>TOTAL EQUITY</b> (page 18, line 24)	\$ 45,368	\$ (1,467,848)	47
48	<b>TOTAL LIABILITIES AND EQUITY</b> (sum of lines 46 and 47)	\$ 2,953,088	\$ 13,817,265	48

\*(See instructions.)



XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ 216,971	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ 216,971	6
	<b>A. Additions (deductions):</b>		
7	NET Income (Loss) (from page 19, line 43)	(171,603)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	<b>TOTAL Additions (deductions) (sum of lines 7-16)</b>	\$ (171,603)	17
	<b>B. Transfers (Itemize):</b>		
18			18
19			19
20			20
21			21
22			22
23	<b>TOTAL Transfers (sum of lines 18-22)</b>	\$	23
24	<b>BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)</b>	\$ 45,368	24 *

\* This must agree with page 17, line 47.

## STATE OF ILLINOIS

Page 19

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

**VII. INCOME STATEMENT** (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

**Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.**

1			
Revenue		Amount	
<b>A. Inpatient Care</b>			
1	Gross Revenue -- All Levels of Care	\$ 13,555,570	1
2	Discounts and Allowances for all Levels	( )	2
3	<b>SUBTOTAL Inpatient Care (line 1 minus line 2)</b>	\$ 13,555,570	3
<b>B. Ancillary Revenue</b>			
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	181,634	6
7	Oxygen	6,499	7
8	<b>SUBTOTAL Ancillary Revenue (lines 4 thru 7)</b>	\$ 188,133	8
<b>C. Other Operating Revenue</b>			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,101	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	25,402	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	4,020	19
20	Radiology and X-Ray	(3,602)	20
21	Other Medical Services	30,778	21
22	Laundry		22
23	<b>SUBTOTAL Other Operating Revenue (lines 9 thru 22)</b>	\$ 57,699	23
<b>D. Non-Operating Revenue</b>			
24	Contributions		24
25	Interest and Other Investment Income***	1,043	25
26	<b>SUBTOTAL Non-Operating Revenue (lines 24 and 25)</b>	\$ 1,043	26
<b>E. Other Revenue (specify):****</b>			
27	<b>Settlement Income (Insurance, Legal, Etc.)</b>		27
28	See Page 19 A	35,761	28
28a			28a
29	<b>SUBTOTAL Other Revenue (lines 27, 28 and 28a)</b>	\$ 35,761	29
30	<b>TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)</b>	\$ 13,838,206	30

2			
Expenses		Amount	
<b>A. Operating Expenses</b>			
31	General Services	1,715,380	31
32	Health Care	4,932,094	32
33	General Administration	3,284,307	33
<b>B. Capital Expense</b>			
34	Ownership	858,544	34
<b>C. Ancillary Expense</b>			
35	Special Cost Centers	3,071,696	35
36	Provider Participation Fee	147,788	36
<b>D. Other Expenses (specify):</b>			
37			37
38			38
39			39
40	<b>TOTAL EXPENSES (sum of lines 31 thru 39)*</b>	\$ 14,009,809	40
41	<b>Income before Income Taxes (line 30 minus line 40)**</b>	(171,603)	41
42	<b>Income Taxes</b>		42
43	<b>NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)</b>	\$ (171,603)	43

\* This must agree with page 4, line 45, column 4.

\*\* Does this agree with taxable income (loss) per Federal Income Tax Return? not yet done If not, please attach a reconciliation.

\*\*\* See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

\*\*\*\*Provide a detailed breakdown of "Other Revenue" on an attached sheet.

Column 1  
Amount

Page 19A

Miscellaneous Income gl 4977	3,603.86
------------------------------	----------

Recovery of Bad Debts (private only, is not offset on Schld V)	16,607.10
Write Off of Old Amounts Due (related to prior yr, not offset on Schdl V)	15,550.18

Total of line 28	35,761.14
------------------	-----------

Facility Name &amp; ID Number Alden Alma Nelson Manor

# 0044891

Report Period Beginning: 1/1/04

Ending: 12/31/04

## XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1	2**	3	4	
		# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage	
1	Director of Nursing	1,696	1,760	\$ 59,020	\$ 33.53	1
2	Assistant Director of Nursing	2,952	3,096	120,100	38.79	2
3	Registered Nurses	31,511	32,711	958,465	29.30	3
4	Licensed Practical Nurses	48,506	51,939	1,135,218	21.86	4
5	Nurse Aides & Orderlies	135,193	142,363	1,552,223	10.90	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	3,628	3,940	48,963	12.43	8
9	Activity Director	2,040	2,080	28,307	13.61	9
10	Activity Assistants	18,930	20,081	222,182	11.06	10
11	Social Service Workers	5,536	5,740	84,128	14.66	11
12	Dietician					12
13	Food Service Supervisor	2,064	2,084	52,012	24.96	13
14	Head Cook	4,416	4,696	50,917	10.84	14
15	Cook Helpers/Assistants	27,298	29,040	247,642	8.53	15
16	Dishwashers					16
17	Maintenance Workers	1,992	2,080	65,787	31.63	17
18	Housekeepers	31,049	32,763	288,467	8.80	18
19	Laundry	7,202	7,929	69,652	8.78	19
20	Administrator	2,048	2,080	101,974	49.03	20
21	Assistant Administrator	6,455	6,615	211,374	31.95	21
22	Other Administrative	10,248	10,625	202,745	19.08	22
23	Office Manager					23
24	Clerical	9,101	9,697	92,983	9.59	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator	4,059	4,295	116,299	27.08	29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,960	2,075	21,760	10.49	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	357,884	377,689	\$ 5,730,218 *	\$ 15.17	34

\* This total must agree with page 4, column 1, line 45.

\*\* See instructions.

## B. CONSULTANT SERVICES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Consultant Cost for Reporting Period	Schedule V Line & Column Reference	
35	Dietary Consultant	Monthly	\$ 9,600	1-3	35
36	Medical Director	Monthly	39,000	10-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	6,432	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	45	2,432	11-3	44
45	Social Service Consultant	12	668	11-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	57	\$ 58,132		49

## C. CONTRACT NURSES

		1	2	3	
		Number of Hrs. Paid & Accrued	Total Contract Wages	Schedule V Line & Column Reference	
50	Registered Nurses		\$ n/a		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		\$		53

A. Administrative Salaries				D. Employee Benefits and Payroll Taxes			F. Dues, Fees, Subscriptions and Promotions	
Name	Function	Ownership %	Amount	Description	Amount		Description	Amount
Gregory Taylor	Administrator		\$ 101,974	Workers' Compensation Insurance	\$ 155,147		IDPH License Fee	\$
Lisa Kaminski	Asst Administrator		56,210	Unemployment Compensation Insurance	15,179		Advertising: Employee Recruitment	1,297
				FICA Taxes	579,554		Health Care Worker Background Check	626
				Employee Health Insurance	70,512		(Indicate # of checks performed 89)	
				Employee Meals	35,338		Surity Bond Fee, Dues & Subscription	4,196
				Illinois Municipal Retirement Fund (IMRF)*			IL Health Care Assoc.	8,105
				Union Health & Welfare	108,665		Related Party - AMS	759
				Dental, Life, Relations, Pension & Misc	45,802			
				Tuition & Drug Test	4,430			
				401k Match, Vaccinations, Empl. Dishonesty	3,318		Less: Public Relations Expense	( )
				Marketing Employ.Benefits Deduction	(6,713)		Non-allowable advertising	( )
							Yellow page advertising	( )
TOTAL (agree to Schedule V, line 17, col. 1)			\$ 158,184	TOTAL (agree to Schedule V,	\$ 1,011,232		TOTAL (agree to Sch. V,	\$ 14,983
(List each licensed administrator separately.)				line 22, col.8)			line 20, col. 8)	
B. Administrative - Other				E. Schedule of Non-Cash Compensation Paid to Owners or Employees			G. Schedule of Travel and Seminar**	
Description			Amount	Description	Line #	Amount	Description	Amount
			\$			\$	Out-of-State Travel	\$
							In-State Travel	
							Gas/Mileage	8,461
							Lodging / Meals staff	17,182
							Related Party - AMS	18,860
							Seminar Expense	
							IL Health Care convention	670
							36 hour course-education	350
							Entertainment Expense	( )
							(agree to Sch. V,	
TOTAL (agree to Schedule V, line 17, col. 3)			\$	TOTAL		\$	TOTAL	\$ 45,523
(Attach a copy of any management service agreement)							line 24, col. 8)	
C. Professional Services								
Vendor/Payee	Type		Amount					
AMS	Management Fees		\$ 1,021,003					
BDO Siedman	Accounting Fees		5,933					
Ken Fisch / Greenberg	Legal Fees		18,638					
Jennings Law / Dana Cons.	401k services		530					
David A Aaby	Legal Fees		20,597					
Cambridge Realty	Refinancing-reversal		(8,000)					
Medi.Com	Billing Consultants		633					
National City	Renew Loan-reversal		(2,494)					
Trimble&Jewell/Williams&McCarthy	Legal Fees		2,022					
Neal Gerber/Clerk of Court/Elite Re	Legal Fees		381					
KPMG	Accounting Fees		123					
Dart Chart	Medicare Consultant		126,462					
TOTAL (agree to Schedule V, line 19, column 3)			\$					
(If total legal fees exceed \$2500 attach copy of invoices.)			\$ 1,185,828					

\* Attach copy of IMRF notifications

\*\*See instructions.

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).  
 (See instructions.)

1		2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1	GT Mechanical - A/C	6/01	\$ 2,021	5	\$ 236	\$ 404	\$ 404	\$ 404	\$ 404	\$ 169	\$ 0	\$ 0	\$
2	GT Mechanical - Chiller	7/01	1,988	5	199	397	397	397	397	201	0	0	
3	CSI Corker - dishwasher	12/01	3,404	5	57	681	681	681	681	623	0	0	
4	no 2002 additions												
5	no 2003 additions												
6	Painting>\$1500 YTD 2004	03/04	1,753					146					
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$ 9,166		\$ 492	\$ 1,482	\$ 1,482	\$ 1,628	\$ 1,482	\$ 993	\$	\$	\$

Facility Name & ID Number Alden Alma Nelson Manor

STATE OF ILLINOIS

# 0044891

Report Period Beginning:

1/1/04

Ending:

Page 23

12/31/04

XX. GENERAL INFORMATION:

- (1) Are nursing employees (RN,LPN,NA) represented by a union? Yes
- (2) Are there any dues to nursing home associations included on the cost report? Yes  
If YES, give association name and amount. IL Healthcare Assoc. \$11,880
- (3) Did the nursing home make political contributions or payments to a political action organization? Yes If YES, have these costs been properly adjusted out of the cost report? Yes
- (4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity? \_\_\_\_\_
- (5) Have you properly capitalized all major repairs and equipment purchases? Yes  
What was the average life used for new equipment added during this period? 10
- (6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$ 23,930 Line 10
- (7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.
- (8) Are you presently operating under a sale and leaseback arrangement? No  
If YES, give effective date of lease. \_\_\_\_\_
- (9) Are you presently operating under a sublease agreement? \_\_\_\_\_ YES X NO
- (10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES \_\_\_\_\_ NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.  
\_\_\_\_\_
- (11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. \$ 147,788  
This amount is to be recorded on line 42 of Schedule V.
- (12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.
- (13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes
- (14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.
- (15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. \$ 35,338 Has any meal income been offset against related costs? No Indicate the amount. \$ \_\_\_\_\_
- (16) Travel and Transportation  
a. Are there costs included for out-of-state travel? No  
If YES, attach a complete explanation.  
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. \$ \_\_\_\_\_  
c. What percent of all travel expense relates to transportation of nurses and patients? 0  
d. Have vehicle usage logs been maintained? Yes  
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes  
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes  
g. Does the facility transport residents to and from day training? No  
Indicate the amount of income earned from providing such transportation during this reporting period. \$ \_\_\_\_\_
- (17) Has an audit been performed by an independent certified public accounting firm? No  
Firm Name: \_\_\_\_\_ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? \_\_\_\_\_ If no, please explain. Not Required
- (18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? Yes
- (19) If total legal fees are in excess of \$2500, have legal invoices and a summary of services performed been attached to this cost report? Yes  
Attach invoices and a summary of services for all architect and appraisal fees.